

Indiana Health Coverage Programs Drug Claim Form

Line Number	Explanation
01	MEMBER NAME: LAST, FIRST: Enter the last name and first name of the member. Required.
02	<p>PRESCRIBER'S NPI: Enter the prescriber's ten-digit NPI number. The prescriber is not required to be an enrolled IHCP provider for the pharmacy to be reimbursed by the IHCP for a pharmacy claim, but is required to have a valid NPI. Required.</p> <p>For assistance in obtaining the prescriber's NPI number:</p> <ul style="list-style-type: none"> • Call the prescriber • Call HP
03	EMERGENCY: Emergency indicator; valid values are YES and NO . Required.
04	PREGNANT: Pregnancy indicator; valid value is YES if patient is pregnant and this medication is related to the pregnancy. Leave this field blank for no. Required, if applicable
05	<p>PATIENT RESIDENCE CODE: Nursing facility indicator. Required when applicable. Valid program values are:</p> <p>00 – Not specified</p> <p>02 – Skilled Nursing Facility</p> <p>03 –Nursing Facility</p> <p>07- Inpatient Psychiatric Facility</p> <p>09 – ICF/MR</p> <p>11 – Hospice</p>
6	RID NO.: Enter the 12-digit member identification number. Required.

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Line Number	Explanation
07	PRESCRIPTION NUMBER: Enter the prescription number. Field accommodates 12 alphanumeric characters. Required.
08	<p>DAW CODE: Brand medically necessary (BMN) indicator. Required. Valid program values are:</p> <p>0 – No product selection indicated – This value is used when the prescriber has prescribed either by brand name or generic name, signed either on the <i>dispense as written (DAW)</i> or <i>may substitute</i> line, but has not properly indicated “brand medically necessary”. This value is also used for brand name products that are not generically available and for items prescribed generically. This value is the only value used for covered OTC drugs, and is to be reported by providers for all such prescriptions.</p> <p>1 – Substitution Not Allowed by Prescriber – This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification.</p> <p>2 – Substitution Allowed-Patient Requested Product Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p> <p>3 – Substitution Allowed-Pharmacist Selected Product Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p> <p>4 – Substitution Allowed-Generic Drug Not in Stock – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.</p> <p>5 – Substitution allowed-brand drug dispensed as a generic – In some cases, providers can purchase brand name drugs at a reduced price that allows them to dispense the brand name drug instead of the generic and the brand name is no more costly to the program than the generic. Use of this value does not penalize a provider when the brand name drug is no more costly to the program than the generic.</p> <p>8 – Substitution allowed-generic drug not available in market – This value is allowed when a generic substitution is not available in the marketplace. Proper use of this code will be closely monitored by Medicaid auditing contractors.</p> <p>9 – Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p>
09	REFILL NUMBER: Refill indicator. If this is an original prescription, enter 00 . If this is a prescription refill, indicate the number of the refill. Valid values in the two-digit field are 00 to 99 . Required.
10	QUANTITY DISPENSED: Indicate the quantity of the item or drug dispensed using the appropriate metric decimal quantity, such as ea, gm, or ml. Maximum field capacity 10 digits. Required.
11	DAYS SUPPLY: Indicate the approximate number of days supply (DS) for the quantity of the drug dispensed. The field accommodates three numeric characters, for up to 999 days. Required.
12	USUAL AND CUSTOMARY CHARGE: Enter the total amount charged for the prescription dispensed. Required.
13	DATE PRESCRIBED: Enter the date prescribed. Required.
14	DATE DISPENSED: Enter the date dispensed. Required.

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Line Number	Explanation
15	NDC NUMBER: Enter the 11 digit NDC code for the drug(s) dispensed. Required.
16	OTHER PAYER AMOUNT PAID: Sum of amount paid by all payers. Enter the Other Payer Amount Paid. Required, if applicable.
17	<p>OTHER COVERAGE CODE: Enter the 2-digit value associated with member's other coverage. Required, if applicable. Valid values are:</p> <p>Blank – not specified</p> <p>00 – Not specified by patient</p> <p>01 – No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available.</p> <p>02 – Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received.</p> <p>03 – Other Coverage Billed – claim not covered - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered.</p> <p>04 – Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received</p>
18	OTHER PAYER - PATIENT RESPONSIBILITY AMOUNT: Amount used by other payer as the amount owed by the patient. Enter the total Other Payer – Patient Responsibility Amount. Required.
19	PROVIDER'S NAME AND ADDRESS: Enter the provider name and address. The address entered in this field must correspond to the location code entered in field 22. Required.
20	BILLING PROVIDER NPI: Enter the appropriate 10-character billing provider NPI number. Required.
21	PROVIDER TYPE: Indicate the appropriate provider type by checking the box preceding value. Required.
22	SIGNATURE OF PROVIDER OR REPRESENTATIVE: Read the statement above the signature line and sign the claim form. The provider or an authorized person designated by the agency or organization must sign and date the claim. A signature stamp is acceptable; however, a typed signature is not acceptable. Required.
23	DATE BILLED: Enter the date the claim was completed. Required.

Indiana Medicaid Compounded Prescription Claim Form Explanation

Field Locator	Explanation
01	MEMBER NAME: LAST, FIRST: Enter the last name and first name of the member. Required.
02	RID NO.: Enter the 12-digit member identification number. Required.
03	<p>PRESCRIBER'S NPI: Enter the prescriber's ten-digit NPI number. The prescriber is not required to be an enrolled IHCP provider for the pharmacy to be reimbursed by the IHCP for a pharmacy claim, but is required to have a valid NPI. Required.</p> <p>For assistance in obtaining the prescriber's NPI number:</p> <ul style="list-style-type: none"> • Call the prescriber • Call HP
04	EMERGENCY: Emergency indicator, valid values are Y for yes and N for no. Required.
05	PREG: Pregnancy indicator; valid value is YES if patient is pregnant and this medication is related to the pregnancy. Leave this field blank for no. Required, if applicable
06	<p>PATIENT RESIDENCE: Nursing facility indicator. Required when applicable. Valid program values are:</p> <p>00 – Not specified</p> <p>02 – Skilled Nursing Facility</p> <p>03 –Nursing Facility</p> <p>07- Inpatient Psychiatric Facility</p> <p>09 – ICF/MR</p> <p>11 – Hospice</p>

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Field Locator	Explanation
07	<p>DAW CODE: Brand medically necessary (BMN) indicator. Required. Valid program values are:</p> <p>0 – No product selection indicated – This value is used when the prescriber has prescribed either by brand name or generic name, signed either on the <i>dispense as written (DAW)</i> or <i>may substitute</i> line, but has not properly indicated “brand medically necessary”. This value is also used for brand name products that are not generically available and for items prescribed generically. This value is the only value used for covered OTC drugs, and is to be reported by providers for all such prescriptions.</p> <p>1 – Substitution Not Allowed by Prescriber – This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification.</p> <p>2 – Substitution Allowed-Patient Requested Product Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p> <p>3 – Substitution Allowed-Pharmacist Selected Product Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p> <p>4 – Substitution Allowed-Generic Drug Not in Stock – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.</p> <p>5 – Substitution allowed-brand drug dispensed as a generic – In some cases, providers can purchase brand name drugs at a reduced price that allows them to dispense the brand name drug instead of the generic and the brand name is no more costly to the program than the generic. Use of this value does not penalize a provider when the brand name drug is no more costly to the program than the generic.</p> <p>8 – Substitution allowed-generic drug not available in market – This value is allowed when a generic substitution is not available in the marketplace. Proper use of this code will be closely monitored by Medicaid auditing contractors.</p> <p>9 – Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</p>
08	<p>REFILL NUMBER: Refill indicator. If this is an original prescription, enter 00. If this is a prescription refill, indicate the number of the refill. Valid values in the two-digit field are 00 to 99. Required.</p>
09	<p>PRESCRIPTION NUMBER: Enter the prescription number. Field accommodates 12 alphanumeric characters. Required.</p>
10	<p>DATE PRESCRIBED: Enter the date prescribed. Required.</p>
11	<p>DATE DISPENSED: Enter the date dispensed. Required.</p>
12	<p>TOTAL QUANTITY DISPENSED: Indicate the total quantity of the compounded prescription. Use the appropriate metric decimal quantity, such as ea, gm, or ml. Maximum field capacity 10 digits. Required.</p>
13	<p>DAYS SUPPLY: Indicate the approximate number of days supply (DS) for the quantity of the drug dispensed. The field accommodates three numeric characters, for up to 999 days. Required.</p>
14	<p>USUAL AND CUSTOMARY CHARGE: Enter the total amount charged for the prescription dispensed. Required.</p>

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15	<p>ROUTE OF ADMINISTRATION CODE: Enter the 2-digit code for the route of administration. Valid route of administration codes are:</p> <ul style="list-style-type: none"> 0 – Not Specified 1 – Buccal 2 – Dental 3 – Inhalation 4 – Injection 5 – Intraperitoneal 6 – Irrigation 7 – Mouth/Throat 8 – Mucous Membrane 9 – Nasal 10 – Ophthalmic 11 – Oral 12 – Other/Miscellaneous 13 – Otic 14 – Perfusion 15 – Rectal 16 – Sublingual 17 – Topical 18 – Transdermal 19 – Translingual 20 – Urethral 21 – Vaginal 22 – Enteral
16	<p>SUBMISSION CLARIFICATION CODE: This code is used when requesting that the compound be processed for approved ingredients only. <i>Please note, failure to use this code will cause a compound to deny it contains any non covered ingredients.</i> Required, if applicable.</p> <ul style="list-style-type: none"> 00 – Not Specified 08 – Process compound for approved ingredients
17	<p>OTHER COVERAGE CODE: Enter the 2-digit value associated with member’s other coverage. Required, if applicable. Valid values are:</p> <ul style="list-style-type: none"> Blank – not specified 00 – Not specified by patient 01 – No other coverage - Code used in coordination of benefits transactions to convey that no other coverage is available. 02 – Other coverage exists-payment collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received. 03 – Other Coverage Billed – claim not covered - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered. 04 – Other coverage exists-payment not collected - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received
18	<p>OTHER PAYER AMOUNT PAID: Sum of amount paid by all payers. Enter the Other Payer Amount Paid. Required, if applicable.</p>
19	<p>OTHER PAYER - PATIENT RESPONSIBILITY AMOUNT: Amount used by other payer as the amount owed by the patient. Enter the total Other Payer – Patient Responsibility Amount. Required.</p>

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20	NDC NUMBER: Enter the 11 digit NDC code for the drug(s) dispensed. Required
21	DESCRIPTION OF INGREDIENT: If there is not an NDC, HRI, or UPC for an ingredient used, the provider can enter a narrative description of the ingredient. However, it is necessary for a product to have an NDC or UPC on file with FDB in order for the product to be reimbursed as part of a compound. Required.
22	INGREDIENT QUANTITY: Indicate the quantity of the item or drug dispensed using the appropriate metric decimal quantity, such as ea, gm, or ml. Maximum field capacity 10 digits. Required.
23	PROVIDER'S NAME AND ADDRESS: Enter the provider name and address. The address entered in this field must correspond to the location code entered in field 25. Required.
24	BILLING PROVIDER NPI: Enter the appropriate 10-character billing provider NPI number. Required.
25	PROVIDER TYPE: Indicate the appropriate provider type by checking the box preceding value. Required.
26	SIGNATURE OF PROVIDER OR REPRESENTATIVE: Read the statement above the signature line and sign the claim form. The provider or an authorized person designated by the agency or organization must sign and date the claim. A signature stamp is acceptable; however, a typed signature is not acceptable. Required.
27	DATE FILED: Enter the date the claim was completed. Required.